operative in this man. The transaminase elevation indicated a greater alcohol intake than admitted, and a day of unusual activity may have enhanced his vulnerability. In the setting of a darkened twilight room, his concentrating on the flashing lights of a video game was enough to initiate the seizure.

Suitable admonitions were offered concerning the proper mixing of alcohol with Pac-Man.

MARTIN TERPLAN, MD
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Acronyms in Medical Papers

TO THE EDITOR: Something irritates me. I suspect I am not the only MD who feels this way. It may be a hidden reaction in many, like it was in those who could not see the emperor's clothes. Those little groups of letters irritate and frustrate me (acronyms). Maybe I am a slow learner, but they slow down my reading and comprehension when scanning a medical paper. I have to stop and look back a few lines, often, to recall what they mean. By the time I've finally caught on to all the cute little groups, the material ends, and I've got a new batch to learn for the next paper. I wonder if I am alone in this feeling, or if others have feelings like mine.

Are acronymical contractions supposed to save time and facilitate comprehension? They fail to do it for me.

I'd like to hear feedback from some of the readers of the journal. My local colleagues agreed with me last time when we discussed it at lunch.

ALFRED G. ROBINSON, MD
Camarillo, California

Comments on Ethical Protocol

TO THE EDITOR: In applying the protocol developed in the July article on ethical problems,[1] the first paragraph on "contracts" seems overly simplistic. Perhaps the primary doctor-patient relationship "contract" is indeed with the child rather than the parents, but it seems unreasonable and unethical to totally eliminate the parents from contractual consideration. The needs, desires and capacities of the parents deserve consideration not only for the sake of the parents but also for the sake of the child. On this basis alone the conclusion that the physician should intervene with the courts might well be wrong.

Furthermore, the first "general assumption" is open to question in terms of the specific case and in general. The "interventionist philosophy" that has dominated medical education and medical standards for a good many years seems to lead most physicians to equate more with better and most with best—that is, the more diagnostic procedures and the more therapeutic interventions that can be justified, on any basis, the better the care. This, despite a very large and convincing body of literature clearly demonstrating that more is often not better but worse and is more than occasionally dangerous to the patient.

It would seem to be the conclusion of the authors that surgical treatment of duodenal atresia in order to preserve the life of a child with Down's syndrome is best for the child, and it might be. However, it is not at all difficult to imagine a scenario of multiple complications following surgical procedures preserving the life of a baby with Down's syndrome with a very low IQ left to be the economic and human responsibility of parents who, wanting no part of such responsibility and angry at having it forced on them, abuse the child, resulting in long-term morbidity and perhaps mortality. Is that really best for the child?

While the guidelines presented in the article may be helpful to physicians, in the individual case much finer judgments are called for. There is considerable doubt that modern medical education is providing the basis for such insights by young physicians. And most of us who are older did not get it during our education nor have many developed it over our years of practice. Perhaps a follow-up article in greater depth is indicated.

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REFERENCE

1. Watts MSM, Bayley C, Healy FA, et al: Ethical problems in medical practice—A protocol for the guidance of physicians (Medical Ethics). West J Med 1982 Jul; 137:83-86

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TO THE EDITOR: The article "Ethical Problems in Medical Practice" by Watts and colleagues[1] is an interesting exercise in establishing theoretical ethical guidelines, but in practice I would find it of little help, as an examination of the case example presented reveals.

The authors chose the difficult and provocative case of a child with Down's syndrome with a single, correctable gastrointestinal lesion. They used their law of "mutual trust" and imply that it is clear that if the law is applied, a physician will choose to intervene surgically. I submit this is not the case, necessarily.

Suppose I, as an ethical physician, believe that

the quality of the patient's life will be very questionable and therefore believe that the operation proposed is not in the patient's best interest. Further, suppose that I believe that death is merely a part and continuation of life and not to be fought off at all costs. I can then apply a law of "mutual trust" and allow the patient to die. In short, how I apply the rule depends on what *I* define as "in the best interest of the patient." As long as my conscience is clear, I can logically opt for or against the proposed operation.

Alas, the formulation of ethical rules in the end makes little difference. What does matter is the beliefs of the people who apply them.

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REFERENCE

1. Watts MSM, Bayley C, Healy FA, et al: Ethical problems in medical practice—A protocol for the guidance of physicians (Medical Ethics). West J Med 1982 Jul; 137:83-86

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TO THE EDITOR: I was delighted to see the article "Ethical Problems in Medical Practice"[1] in the last issue. These aspects deserve the attention they recently have been receiving. The protocol you and your coauthors presented is both practical and useful. However, I must take issue with the application of it that occurred in your case study. In simplifying the problem, I believe you introduced error and arrived at a conclusion that is by no means universally acceptable or certain. Let me explain.

The *Rule of Mutual Trust* and the *Golden Rule* are conceptually separate and distinct but practically inseparable and largely overlapping. No professional can arrive at an opinion or belief as to the best interest of the patient except from the reference point of his or her own personal philosophy and beliefs. This may in some cases be interconnected with the *Religious Rule* whenever and to the extent the personal beliefs of the professional are determined by the professional's religious convictions. Thus, in my opinion the Golden Rule *always* applies and the Religious Rule often applies whether we recognize it or not. With this understanding my conclusion differs from that of the committee that acted in your case study.

It is my belief that an unwanted child is doomed to a miserable existence and that this is specially so if the child is handicapped. It is further my belief that *human life* as opposed to biologic life implies self-consciousness and the ability to influence and control, at least to some extent, one's environment. That belief includes the concept that quality of life affects the value of life and that sometimes, under some circumstances, death is preferable. This belief does not mean that I devalue life or deny the sanctity of life. It does mean that I deny that biologic existence under any and all circumstances is the ultimate and immutable value.

Had I been caring for this child and its parents I would have honored their decision.

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San Diego

REFERENCE

1. Watts MSM, Bayley C, Healy FA, et al: Ethical problems in medical practice—A protocol for the guidance of physicians (Medical Ethics). West J Med 1982 Jul; 137:83-86